

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

DEPARTMENT OF HEALTH

**MEDICAL ASSISTANCE
ADMINISTRATION**

REPORT OF RE-INSPECTION



**CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL



Inspector General

June 17, 2003

Mr. James A. Buford
Director
Department of Health
825 North Capitol Street, N.E., Suite 4400
Washington, DC 20002

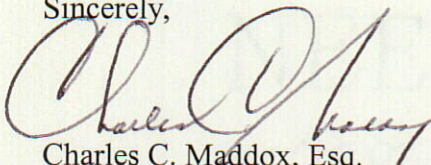
Dear Mr. Buford:

Enclosed is our *Report of Re-inspection of the Medical Assistance Administration (MAA)*. We conducted the re-inspection of MAA as a follow-up to our initial inspection that took place between February and April 2000. Re-inspections and follow-up reports are the key components of the OIG compliance process. This process was developed to assist District managers in improving service delivery by implementing the findings and recommendations that were agreed upon at the conclusion of the initial inspection.

Re-inspections are a review of matters that have already been discussed in detail, and as is true in this case, there is usually agreement on the majority of our findings and recommendations. However, please note that we do not send re-inspection reports such as this one out to agencies for comment prior to publication. Of the 45 recommendations made in our initial inspection, MAA has complied fully with 35, 3 are in partial compliance, and 7 have not been complied with. I commend MAA for the significant improvements represented by those recommendations complied with, and ask that MAA managers be encouraged to work diligently and expeditiously to bring the agency into full compliance on the remaining issues.

If you have questions or comments concerning this report or other matters related to the re-inspection, please contact me at the number below or Alvin Wright, Jr., Assistant Inspector General for Inspections and Evaluations at (202) 727-9249.

Sincerely,


Charles C. Maddox, Esq.
Inspector General

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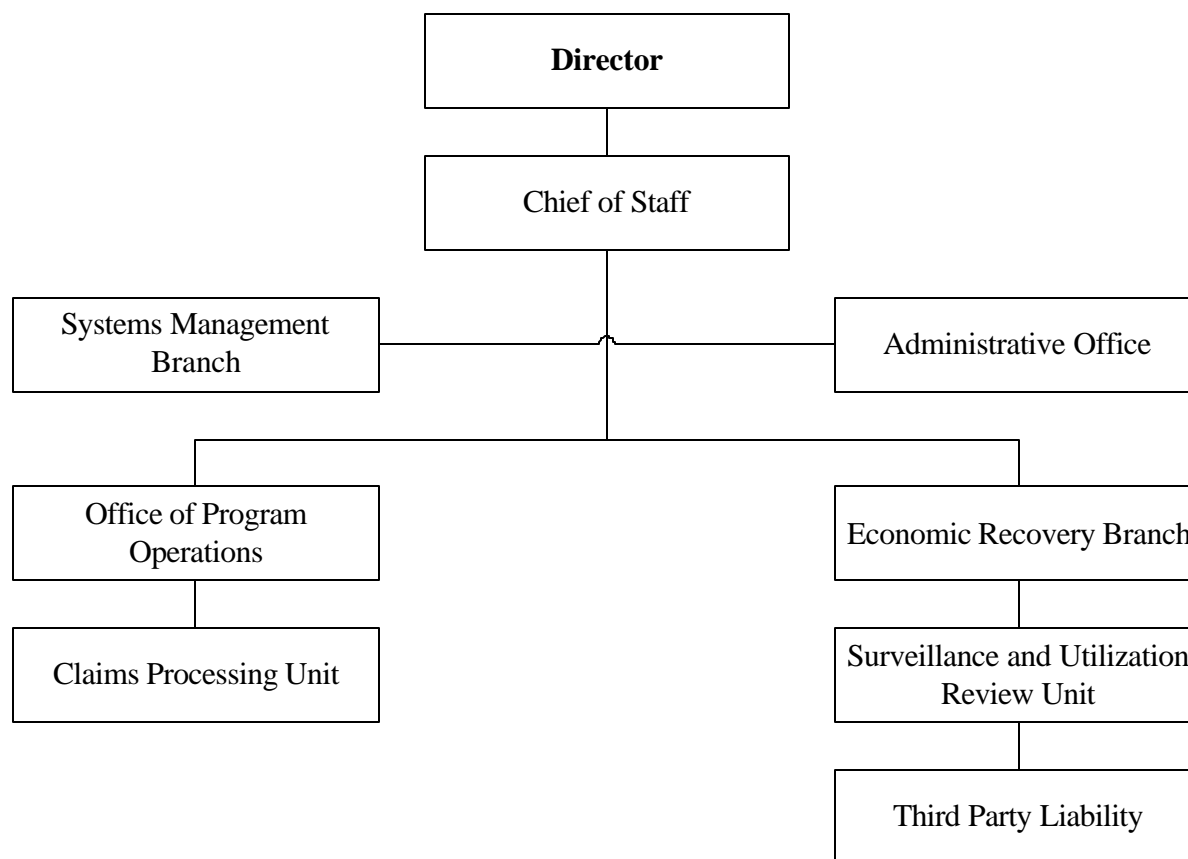
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Mission Statement

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness, and economy in operations and programs. I&E's goals are to help ensure compliance with applicable laws, regulations, and policies, to identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.



Medical Assistance Administration



GLOSSARY OF TERMS

ACEDS	Automated Client Eligibility Determination System – computer system used to determine benefit eligibility.
Bendex System	A database used by the Health Care Finance Administration which contains the names of eligible Medicare recipients.
DOH	Department of Health.
Encounter Data	Information on managed care providers and recipients.
EOB	Explanation of Benefits – a list of the services paid on behalf of each Medicaid recipient.
Exception Report	A report listing providers or recipients whose patterns of use of the Medicaid Program are outside of normal parameters.
Fee-for-Service	Amount charged by providers for services rendered to Medicaid recipients.
HSS	Health Systems Specialist.
IMA	Income Maintenance Administration.
MAA	Medical Assistance Administration.
Medicaid	A program of medical aid designed for those unable to afford regular medical service and financed by state and federal governments.
Medicare	A federal-state matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low income and resources.
MFCU	Medicaid Fraud Control Unit.
MMIS	Medicaid Management Information System
OIC	Office of Investigations and Compliance
ROI	Report of Inspection
SUR	Surveillance and Utilization Review
TPL	Third Party Liability

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INTRODUCTION

INTRODUCTION

Background and Perspective

The re-inspection of the Medical Assistance Administration (MAA) was a follow-up to the findings and recommendations issued in the initial inspection that took place from February to April 2000. The inspection team found that 35 of the original 45 original recommendations (77%) were in full compliance, 3 were found to be in partial compliance, and 7 are considered to be not in compliance. This follow-up inspection and report are part of the compliance process that the Office of the Inspector General (OIG) has developed to help District managers work toward continuous improvement in the delivery of services to residents and others who have a vested interest in the success of the city.

MAA is the single state agency responsible for administering Title XIX of the Social Security Act, the Medical Charities program, and other health care financing initiatives for the District of Columbia (District). In addition, MAA:

- develops eligibility, service coverage, and payment policies for the District's health care financing programs;
- ensures that District health care programs take full advantage of federal funding for services for the indigent and uninsured;
- manages the use of health care services and the cost of care in District health care financing programs; and
- analyzes existing health care financing policies to ensure that they are promoting efficient, effective, and economical care.¹

MAA has 82 employees serving at 2100 Martin Luther King Avenue, S.E., and 825 N. Capitol Street, N.E.

Scope and Methodology

The inspection team (team) held an entrance conference with the Chief of the Office of Program Integrity and other MAA senior managers in January 2003.

The re-inspection reviewed MAA's compliance with the recommendations made in the initial MAA Report of Inspection, No. 00-0002HC (Report). The team conducted interviews, inspected facilities, directly observed major work processes, reviewed documentation, and inspected work areas. The team also conducted an anonymous survey of MAA employees, but due to the less than 50% response rate was unable to perform a statistically valid analysis of the results.

¹ D.C. Department of Health: Administrations and Offices: Medical Assistance Administration, http://dchealth.dc.gov/about/index_maa.shtml, April 1, 2003.

INTRODUCTION

Format of This Report

Each finding in the original Report of Inspection is repeated followed by a summary of the status of MAA's compliance with the recommendations agreed to. Please see Appendix for a complete list of the original findings and recommendations with the current status of those recommendations.

Findings and Recommendations: DIRECTORATE OPERATIONS

DIRECTORATE OPERATIONS

Original Finding:

1. **Neither MAA nor any other appropriate District agency has taken action to recover millions of dollars in erroneous Medicaid payments first identified in a January 15, 1997 audit by the Office of the Inspector General.**

Current Status: In Compliance.

The Medicaid Management Information System (MMIS) is a computer system that tracks, processes, and adjudicates Medicaid claims. MMIS processes tens of thousands of claims daily. In accordance with federal law, the District determines Medicaid eligibility and the MMIS contractor is responsible for ensuring that providers receive payments only for services provided to eligible recipients. During the original inspection, the team followed up on the January 1997 OIG audit report recommendation that District officials pursue recovery of Medicaid payments totaling \$34.7 million erroneously paid to providers because of errors in MMIS. The report also recommended the recovery of fees paid to the MMIS contractor for 247,000 claims processed for ineligible recipients between 1993 and 1996. The 2000 inspection team found that as much as \$89.4M had been paid to providers on behalf of ineligible Medicaid recipients between 1993 and 1996. In April 2000, District and federal officials formed a working group to explore options for recovering the erroneous Medicaid payments. The Medicaid Fraud Control Unit (MFCU) of the OIG assumed the lead in the fund recovery effort. On April 23, 2003, a settlement was announced in which the contractor agreed to repay \$13 million to the District government.

Original Finding:

2. **Systems Management Branch employees bypass Automated Client Eligibility Determination System (ACEDS) supervisors when requesting database changes and reports. As a result, ACEDS supervisors often are unaware of changes that have been made to the ACEDS/MMIS interface.**

Current Status: Agency disagreed with the original finding.

OIG accepted the agency's assessment. The finding was not reviewed during the re-inspection.

Original Finding:

3. **MAA is not in compliance with federal regulations regarding training and employing sub-professionals and volunteers.**

Current Status: Partially in Compliance.

During the original inspection, the team found that MAA was not in compliance with Medicaid State Plan and Code of Federal Regulations requirements regarding the training of agency personnel, volunteers and sub-professionals. For example, the agency was not in compliance with federal requirements to establish a training program for agency personnel that provided "initial in-service training for newly appointed staff and continuing training

DIRECTORATE OPERATIONS

opportunities to improve the operation of the program,” nor did the agency have a plan for using non-paid volunteers or providing volunteers with training 42 C.F.R. § 432.30, 432.32. In addition, some senior managers were unaware that the State Plan had training requirements.

Training of agency personnel

Not in Compliance. During the re-inspection, the team found that training within the agency has improved, but is not being provided across the board. Some agency personnel receive training opportunities and attend professional meetings, while others who should do not.

MAA staff members, who are themselves relatively new users of MMIS, are used to train new MAA employees on the system. The current MMIS, implemented in July 2002, has many features, reports, and capabilities that were not in the old system. Most MAA employees received several days of training prior to the system’s initial implementation, but have received no further training. Many employees stated that the initial training was received before the system was fully implemented. As a result, they did not have any experience with the system as it actually functions and were unable to fully benefit from the training. New employees stated that they would like to receive formal training on the MMIS, and others stated that they would like to attend refresher training now that they have used the system. The inspection team reviewed the MMIS contract and found no provisions for contractor-provided training of new MAA personnel or refresher training for the current staff.

Training of volunteers and interns

In Compliance. The team found that MAA uses student interns from Howard University’s Pharmacy and Medical schools to assist in the Quality Assurance Unit and the Medical Director’s Office. MAA and AARP² collaborate on a program where senior citizen volunteers make calls to Medicare clients to check on the services provided. These volunteers are recruited and trained by AARP. In addition, the MAA Policy Branch provided training to MAA senior managers on the training requirements of the Medicaid State Plan in 2001, but no further training sessions have been provided.

² AARP, the organization formerly known as the American Association of Retired Persons, is a nonprofit membership organization dedicated to addressing the needs and interests of persons 50 and older.

Findings and Recommendations:

SURVEILLANCE AND UTILIZATION REVIEW UNIT (SUR)

Original Finding:

4. **The SUR Unit lacks sufficient staff to effectively perform utilization reviews of the Medicaid program to detect possible fraud and abuse.**

Current Status: Not in Compliance.

The federal government mandates that each state is required to have a Medicaid post-payment review process to review recipient utilization, review provider utilization, and identify exceptions so that the agency can correct mis-utilization practices. Within MAA, the SUR Unit was tasked with performing post-payment reviews. During the initial inspection, the team found that the SUR Unit had only 5 staff members to review approximately 30,000 service providers and 125,000 recipients in the Medicaid program. The team also found that few providers, even those who consistently appear on exception reports,³ were audited for potential fraud or abuse of the Medicaid program.

Since the initial inspection, MAA has reorganized the post-payment review process. Several members of the SUR staff were reassigned to the new Office of Investigations and Compliance (OIC). The OIC assumed surveillance functions previously performed by the SUR Unit, while the SUR Unit now focuses primarily on utilization review. The SUR Unit has four staff members and a Director (who is also Director of the Third Party Liability Program), while the OIC has four staff members, a supervisor and a Director. Both units have several vacancies.

The team found that the following problems have hindered the SUR unit's program effectiveness:

1. Three of the four staff members in the SUR Unit are newly hired. Staff members state that due to their inexperience, they conduct many tasks as a group. As a result, the group is unable to review as many exception reports as a more experienced staff.
2. Newly hired SUR employees have received most of their training from the remaining experienced SUR staff member and the Unit Director. One training session with the OIC was also provided. Employees state that they have not received any training from the contractor on how to use the MMIS computer system, nor have they attended formal training on Medicaid surveillance or utilization review. As a result, SUR Unit employees have not received formal training on critical elements of their job.
3. Managers and staff stated that the SUR subsystem of the MMIS did not generate routine (e.g., monthly or quarterly) exception reports during the development period for the new contractor and still does not generate routine exception reports

³ The MMIS computer generates exception reports of providers or recipients who incur excess charges or service visits beyond the norm. These reports are used as a starting point in the post-payment review process.

SURVEILLANCE AND UTILIZATION REVIEW UNIT (SUR)

in a format with the parameters that the SUR Unit requires. As a result, the group does not have regular access to the most current information on recipient and provider utilization patterns.

Original Finding:

5. **The SUR unit has no written policies governing the terms and conditions of repayments by providers when they have been overpaid.**

Current Status: Not in Compliance.

During the previous inspection, the team noted that there were no written policies and procedures for negotiating repayment plans with providers who have been found to owe the Medicaid program. During the past year, the SUR Unit developed written policies and procedures for audits and established repayment terms for overpayments made to Freestanding Mental Health Clinics, but not other providers. The Unit does not have written policies and procedures, including repayment schedules, for most of the other aspects of the program. Repayment schedules are negotiated based on the employee's best judgment and the provider's willingness and ability to pay. The usual term for a repayment schedule is one year, but employees state that longer repayment schedules have been established. Once a repayment agreement is reached, the case is sent to the Program Operations Branch to initiate collection.

Original Finding:

6. **Deleted.**⁴

Original Finding:

7. **The Surveillance and Utilization Review Subsystem (SURS) of the MMIS is outdated and inefficient compared to systems being used by other states.**

Current Status: In Compliance.

The Surveillance and Utilization Review Subsystem (SURS) is a federally required component of MMIS. This database identifies providers whose claims for services are unusual, and recipients whose patterns of use of Medicaid services are questionable. During the initial inspection, the team found that the MMIS technology being provided to the District of Columbia by its contractor was a first generation computer system developed in 1982. The system was not user-friendly and required that all reports be requested from and produced by the contractor.

Since that inspection, MAA has procured a new contractor and a new MMIS. The new MMIS was implemented in July 2002. The new system has an improved graphical interface and

⁴ As Finding 6 had no recommendation, it is deleted from this Compliance Report of Inspection.

SURVEILLANCE AND UTILIZATION REVIEW UNIT (SUR)

is more user friendly. The new system also has a large list of standard reports that are generated according to a production list and can be accessed at any time.

Original Finding:

- 8. Parameters for the MMIS SURS have not been updated and the SUR staff is not trained on how to change them.**

Current Status: In Compliance.

During the initial inspection, the team found that the SUR Unit supervisor and her staff had not been trained on how to change MMIS parameters in order to identify recipients or providers whose Medicaid use fell outside of predefined guidelines. Consequently, the staff had to rely solely on predefined exception reports and was limited in its ability to identify emerging trends in false Medicaid claims.

With the implementation of the new MMIS, SUR supervisors were able to participate in establishing the parameters that would be used for predefined SUR reports. The SUR staff often uses these predefined reports as the initial source of information for investigations. Once a provider or trend has been identified, the staff requests specific reports from the MMIS contractor. A data warehousing function that would allow staff to access Medicaid data and generate their own reports has not been implemented.

SUR employees received initial training from the MMIS contractor and have received other in-house training as well to assist them in enhancing their investigative abilities.

Original Finding:

- 9. The MMIS contractor has not provided sufficient training to enable SUR employees to develop requests for required reports.**

Current Status: Not in Compliance.

MMIS is designed to produce reports for use by the SUR Unit in order to develop comprehensive profiles of the utilization of services by Medicaid providers and recipients. These reports are used to detect program fraud and abuse, monitor the quality of the system, and help develop Medicaid program policies. Since the initial inspection, MAA has procured a new contractor for its MMIS system. Some employees stated that they received training on how to request reports, yet not all employees received training from the contractor. The contractor provided training before the system was fully implemented and many employees feel that they need additional MMIS training. Management has neither implemented alternate training for employees who were not trained initially, nor refresher training courses for those who need them. SUR personnel need a working knowledge of system capabilities and the ability to fully utilize them.

Original Finding:

- 10. Some SUR personnel are not adequately trained to detect provider fraud and abuse or how to conduct provider audits.**

Current Status: Not in Compliance.

Following the initial inspection, MAA improved its ability to internally detect provider fraud and abuse by changing its organizational structure. At the time of the initial inspection, the SUR unit was responsible for both surveillance and utilization review. Currently, SUR is only responsible for utilization review. During the restructuring of MAA, the OIC was developed to handle surveillance of suspected waste, fraud, and abuse within the District's Medicaid program. The mission statement of the OIC is to review claims, to identify errors, incorrect payments, possible fraud or billing abuse, and to determine where corrective action is required. Under the current organization structure, SUR refers all questionable claims to the OIC which investigates further. If waste, fraud, or abuse are found, cases are referred to the Medicaid Fraud Control Unit (MFCU) of the OIG. However, not all OIC cases come from SUR. OIC develops a significant number of cases independently.

The OIC conducted training in the detection of provider fraud and abuse; however, the SUR unit did not receive this training. Although MAA has been restructured so that the OIC handles most of the internal fraud and abuse cases, in many ways, SUR is still one of MAA's main lines of defense for the detection of fraud and abuse. SUR employees stated that they received some on the job training, but that this training was not sufficient and they require more in the area of detecting fraud and abuse.

Original Finding:

- 11. The SUR Unit lacks the equipment necessary to effectively conduct audits.**

Current Status: Not in Compliance.

As noted in the original inspection, the unit still lacks basic data processing equipment, such as laptop computers, necessary to do on-site audits. Although most SUR employees now have desktop computers with adequate memory and software, they are not sufficient to enable employees to perform their jobs efficiently. The SUR supervisor stated that her unit still needs cellular phones and at least one government vehicle for on-site visits. Currently, employees use privately owned vehicles and have the option of being reimbursed for mileage.

Original Finding:

12. **The SUR Unit has no written policies and procedures governing how the unit conducts its daily operations.**

Current Status: Not in Compliance.

There are still no written policies and procedures that support most of the major functions of the SUR unit. Employees could explain how they carried out most of their daily tasks, but there were no written descriptions of how they should be done. However, the supervisor maintains policies and procedures for audits of Freestanding Mental Health Clinics and Explanation of Medicaid Benefits.

Original Finding:

13. **SUR Unit supervisors have not developed written performance standards for unit personnel.**

Current Status: Partially in Compliance.

Not in compliance. SUR employees have written performance standards; however, not all have accurate position descriptions. One employee stated that his performance standards did not match his job description. He is performing the duties of a Nurse Consultant and training other Nurse Consultants, yet his job description is that of a Mental Retardation Specialist.

In compliance. Employees stated that they received periodic counseling and that the evaluation process was fair.

Findings and Recommendations:

THIRD PARTY LIABILITY SECTION

THIRD PARTY LIABILITY SECTION

Original Finding:

14. **Resources for the operation of third party recovery efforts are limited. Overall revenue recoveries are not maximized.**

Current Status: Not in Compliance.

The Third Party Liability (TPL) section is responsible for discovering payment sources other than Medicaid to pay for recipient health care, as required by District and federal law. These sources include private health insurance, Medicare, employment-related health insurance, workers compensation, court judgments, settlements from liability insurer, probate estate recoveries, long-term care insurance, medical support from non-custodial parents, and other federal programs.

During the initial inspection, the team noted that MAA's in-house operations for TPL recoveries were handicapped for many reasons, including not having a direct MMIS online communication link, deficient MMIS programming, lack of training and performance standards, poor work environment, and reporting inadequacies. Recovery efforts in fiscal years 1998 and 1999 totaled \$9.16 million and \$4.66 million respectively. These totals reflect recovery efforts made by MAA and the TPL contractor for health insurance claims, casualty claims, probate-estate and medical support from non-custodial parents.

Since the initial inspection, MAA stopped using a contractor for TPL recoveries. Instead, all recovery efforts are performed in-house by TPL employees. The team noted that TPL has made some significant improvements. For example, TPL has installed a direct MMIS online communication link to each employee's workstation. Employees have taken computer training classes through the Center for Work Force Development at the University of the District of Columbia. Management has developed performance standards, and TPL has moved to a better work environment.

However, according to management, TPL cost recovery efforts are handicapped by the lack of a TPL subsystem in the MMIS. This system would automatically process cost avoidance claims once received in TPL, automatically bill health insurance carriers once TPL identified an insurer, and would identify claims for which retroactive Medicare coverage exists. Cost recovery efforts have continued to decline with recoveries totaling \$2.4 million in fiscal year 2002 and \$1.1 million to date in fiscal year 2003.

Management stated that TPL has been without a subsystem since July 2002, and that all recovery efforts have to be completed manually.

**Findings and
Recommendations:**

**OFFICE OF
PROGRAM OPERATIONS**

OFFICE OF PROGRAM OPERATIONS

Original Finding:

15. **MAA employees cannot account for many claims that are pending payment that have been sent to MAA for review.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this finding as indicated in the initial ROI. The MMIS is designed to automatically verify claim data prior to payment. There were at least 1,587 claims, some dating back to 1990, pending review as of February 2000.

According to the Chief, the new MMIS is fully automated and is working efficiently. Claims continue to go through various stages prior to final approval. Claims received by the contractor are imaged⁵ into MMIS. As each claim is entered into MMIS, it is assigned an edit code. Edit codes serve two purposes; first they alert MAA employees that a claim is pending in their area, and secondly, they act as a tracking mechanism. Edit codes were reduced from 999 in the old system to 600 in the current system.

According to the Chief, claims accountability issues were abated with the implementation of the new MMIS. During the transition to the new contractor, MAA adjudicated (denied) pending claims and required providers to resubmit their claims with the new contractor.

The chief commented that all claims pending in MMIS can be tracked.

Original Finding:

16. **Monitoring of out-of-state-claims that have been placed in pending status due to a lack of rate information is insufficient and irregular.**

Current Status: In Compliance.

As indicated in the initial ROI, the Chief of Program Operations disagreed with this finding in part. During the initial inspection, an MMIS report showed 496 claims pending payment with disposition dates as far back as 1990. This was due to the lack of rate information needed to process payments. Since then, out-of-state claims pending payment due to the lack of rate information has significantly decreased. According to the Chief, those claims were adjudicated during the transition to the new contractor.

The Chief provided the team with a January 22, 2003, MMIS report titled "Suspense File Analysis" which showed 55 claims pending payment due to the lack of rate information. Unfortunately, the report only showed claims pending 59 days or less, but a review of the Program Operations files showed no claims pending for more than 59 days.

⁵ Imaging is a process where claims are digitally scanned directly into MMIS, eliminating data entry by the contractor, thus minimizing errors during the transfer of information.

OFFICE OF PROGRAM OPERATIONS

Program Operations has one employee who is responsible for processing out-of-state claims. There were no written policies and procedures for processing out-of-state claims available for review; however, an in-house document showing the steps used for processing out-of-state claims was available.

The team noted that MAA had not developed a tracking system as recommended in the initial inspection to log claims that have been sent to other states for information and are awaiting a reply. However, a review of claims showed consistency in the manner in which rate requests were generated. All rate requests were made within 7 days of receipt in MAA, and all rate request packages contained an introduction letter to the out-of-state Medicaid agency, a rate request form, and a copy of the claim.

Original Finding:

- 17. There is confusion within Program Operations regarding the processing of \$2.6 million in billed claims from out-of-state providers.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this finding as indicated in the initial ROI. During the initial inspection, a MMIS report showed \$2.6 million in billed claims that were pending for lack of out-of-state provider certification. Since then, MAA has significantly reduced the dollar amount of billed claims from out-of-state providers. A January 22, 2003, MMIS report titled "Claims Exception Report" showed 69 claims pending for out-of-state rates with a total billing of \$442,323.89.

According to the Chief, out-of-state claims are processed in the same manner as other claims once rate information is received from the state. The team requested a copy of the policies and procedures; however, a copy was not provided.

Original Finding:

- 18. Claims that are pending payment status are being resubmitted by providers for processing in violation of the Medicaid State Plan regulation.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this recommendation as indicated in the initial ROI. During the initial inspection, the team reviewed 224 pending claims and found that 21 of those claims had been submitted two to three times. The Medicaid State Plan only allows those denied claims appearing on the Provider Remittance Advice to be resubmitted.

According to the Chief, this issue was abated with the implementation of the new MMIS in July 2002. The new system is programmed to deny resubmitted claims, a programming feature that was not available in the old MMIS.

OFFICE OF PROGRAM OPERATIONS

ACS provided the inspection team an ad hoc report dated February 11, 2003, that showed 5,420 claims had been denied as duplicates since July 2002.

Original Finding:

19. **The Program Operations staff is accepting providers' personal checks instead of the required Adjustment/Void forms for refunds of money owed to Medicaid for duplicate claims or overpayment of claims.**

Current Status: Status: In Compliance.

During the initial inspection, the team noted that providers were using personal checks to refund money owed to the Medicaid program for overpayments or refunds instead of the authorized adjustment forms. Consequently, when personal checks were accepted, providers' claims history file accounts were not adjusted and their refunds were not reflected in the database. Furthermore, providers complained that repayments were reflected on the federal tax Form 1099.

In July 2000, MAA incorporated a new program into MMIS titled "History Only Voids (HOV)." As a result, MAA discontinued use of the Adjustment/Void form. The new procedure allows providers to submit personal checks for refunds of money owed to Medicaid for duplicate claims or overpayment of claims. Upon receipt of a check, MAA employees process provider checks and perform manual adjustments to accounts through the HOV; these adjustments remove the claim from the providers account in addition to amending the provider's tax Form 1099.

Providers also have the option of submitting either a Health Insurance Form (HCFA-1500) or Universal Billing Form (UB92). MMIS automatically processes these forms while updating the provider tax Form 1099.

Original Finding:

20. **Some providers send unnecessary medical records along with claims. These records often contain confidential patient information that is thrown into the trash without being shredded.**

Current Status: In Compliance.

During the initial inspection, the team noted that some providers were sending the entire medical record of recipients to the contractor along with claims, when only the medical summary or operative reports were required. The team also noted that the remaining documents of the claims package were thrown into the trash intact, violating confidentiality standards.

According to MAA management, some providers, particularly hospitals, continue to submit unnecessary medical records with confidential information pertaining to recipients when submitting claims. Management stated that providers received verbal instructions during enrollment/training sessions held with the contractor from February to June 2000 regarding the

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documents necessary to complete claims processing. Management stated that MAA has not developed any written procedures, nor have any guidelines been incorporated into the provider manual specifying the required documents for completing claims processing.

Interviews with both MAA management and the contractor revealed that excess documents are no longer thrown into the trash. Instead, all documents submitted by the provider are imaged into MMIS. After imaging, claims are prepared for storage.

The team noted that both MAA and the contractor have shredders available to dispose of unnecessary documents.

Original Finding:

21. **MAA pays claims for residual amounts billed to Medicaid without knowing the requisite medical procedure codes or amounts already paid by Medicare. This could result in payments being made that exceed the allowable amount.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this finding as indicated in the initial ROI. During the initial inspection, the team noted that the contractor was receiving claims that had already been paid in part by Medicare. Crossover claims⁶ were being entered into MMIS without noting the medical procedure code and amount that had already been paid by Medicare. Without this information, the Medicaid program could not check to see if the amount already paid by Medicare or another third party payer exceeded Medicaid thresholds.

The Chief stated that the implementation of the current MMIS in July 2002 abated this issue. The current system processes the entire claim with procedure codes and checks thresholds for payment amounts. The contractor keys payment information into MMIS from the Explanation of Benefits (EOB) form⁷. MAA verifies the amount listed on the EOB as submitted by the provider. If the reimbursement amount of the service paid by Medicare or another third party payer is equal to or greater than what Medicaid is authorized to pay, Medicaid pays nothing.

⁶ Claims that have received partial payment by Medicare and still have a residual balance to be paid by Medicaid or another third party insurer.

⁷ A form that shows a listing of services paid on behalf of Medicaid.

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Original Finding:

22. **Adjustments or additions to pricing are not documented as required by the Code of Federal Regulations.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this finding in part as indicated in the initial ROI. During the initial inspection, the team noted maximum rates listed for services provided by Medicaid in the State Plan but were unable to locate documentation for pricing medical procedures not in MMIS. As a result, medical procedures listed on claims but not priced in MMIS were sent to Program Operations for review.

The Chief stated that due to the complexity of some medical procedures, MMIS cannot always calculate a reimbursement rate. Program Operations conducts a review in order to determine the rate. He also stated that MAA uses Medicare guidelines to determine the fee schedule. For example, if Medicare pays \$100 for a service, Medicaid pays 80% reimbursement or \$80.

The Chief stated that reimbursement rates are based on budget implications and are established by the Audit and Finance Branch. MAA currently calculates rates at 80% of the Medicare fee. All pricing and procedure codes are based on Medicare pricing.

The Chief provided several examples of change forms and memorandums authorizing the contractor to make adjustments in MMIS. Once adjustments are made, the contractor provides MAA with a written confirmation that changes were completed. The Chief also provided a report generated by the contractor titled "Provider Update Activity" dated January 16, 2003, that showed a comparison of claims before and after adjustments have been made in MMIS. MAA maintains these reports as an audit trail and verification of changes made in MMIS.

Original Finding:

23. **There is no system to verify that recipients have received services billed to Medicaid.**

Current Status: In Compliance.

The chief of Program Operations disagreed with this finding in part as indicated in the initial ROI. During the initial inspection, the team noted that the contractor mailed recipients Explanation of Benefits (EOB) listing the services paid by Medicaid.

According to the Deputy Chief of Program Operations, MAA is compliant with federal guidelines set forth by the Health Care Financing Administration (HCFA) as it pertains to EOBs. She stated that the contractor continues to randomly select and mail EOBs to recipients. The Deputy Chief provided an ad hoc report from the contractor that showed approximately 300 EOBs were mailed per month to recipients since July 2002. She did not elaborate on the number of notices returned; however, she estimated the returns to be minimal.

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An interview with the Chief disclosed that Program Operations had not received any EOB responses within the past year. He commented that follow-up activities were no longer handled in Program Operations and that responsibility had been transferred to the OIC. He further commented that recipients are not required to return the notices unless services listed were not received or there is a discrepancy in billing. In the event a notice is returned to Program Operations, it is forwarded to the OIC.

In an effort to assist recipients in reporting Medicaid fraud and abuse, MAA established a toll free 1-800 telephone number.

Original Finding:

- 24. The telephone system in Program Operations makes it difficult to contact a live person.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this finding in part as indicated in the initial ROI. During the initial inspection, the team noted that the main number for Program Operations was provided as a contact number to Medicaid recipients and providers. As a result, callers encountered a voice mail tree when no one was available to answer the call, calls were rolled into the general telephone mailbox, or callers were routed through the voice processing system where a recording implied operator assistance was available. However, instead of receiving operator assistance, callers were routed through a telephone loop of recordings.

Interviews with MAA management disclosed that issues relating to making telephone contact with Program Operations employees have been abated. MAA installed a new telephone system approximately two years ago. The system has direct dial capabilities, which enables recipients and providers to contact Program Operations employees directly. The system also has voice messaging capabilities, which allows callers to leave messages.

During installation of the new system, MAA utilized a pre-recorded message that notified callers of the change in telephone numbers and disseminated a telephone listing to providers. Program Operations has both a receptionist and a clerk whose responsibility is to answer and direct calls received through the main telephone number.

The team placed random calls to selected Program Operations employees and did not experience any difficulty making contact.

Original Finding:

- 25. Telephone calls received by members of the Program Operations staff from recipients and providers are not logged or tracked.**

Current Status: In Compliance.

The Chief of Program Operations disagreed with this finding in part as indicated in the initial ROI. During the initial inspection, recipients and providers complained that they received conflicting information from Program Operations employees when making inquiries by telephone and that they were unable to determine which employee provided the information because employees did not maintain a telephone log to track calls. The Chief commented that the logging and tracking of telephone calls from recipients and providers was not an effective use of employees' time. Furthermore, the chief stated that the installation of a new telephone system significantly decreased recipient and provider complaints because callers were able to contact the applicable employee directly.

The chief commented that although there is no written policy, recipients and providers are encouraged to submit written requests if they experience problems with their claims that cannot be resolved by telephone. He commented that 95% of inquiries are responded to and resolved by telephone; however, written responses are prepared for his signature by Program Operations employees for those claims requiring a detailed explanation. The team considers this situation to be abated.

Original Finding:

- 26. System errors in the MMIS have caused incorrect cross-referencing of recipient files.**

Current Status: In Compliance.

The chief of Program Operations disagreed with this finding as indicated in the initial ROI. During the initial inspection, the team noted that approximately 1600 recipient files were experiencing cross-referencing difficulties, which affected recipient eligibility and could possibly deny services incorrectly. This problem existed for approximately two years, and resolution was handled on a case-by-case basis between MAA and the contractor as opposed to correcting the problem through a systematic fix.

MAA management acknowledged that cross-referencing issues trace back to the ACEDS computer system. The MMIS maintained records for multiple people using the same number and for the same person with multiple numbers. The previous contractor attempted to cross-reference records by using a recipient number field, however, the merged records were often incorrect. MAA acknowledged that they had no way to correctly separate records in an automated fashion.

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According to the Chief, this issue was abated with the implementation of the current MMIS. When MAA converted to the new MMIS, they did a 100% data reconsolidation of the 1600 merged recipient files and performed a manual conversion. The Chief stated that during this conversion process, MAA rejected any duplicates or questionable recipient records until they were researched and cleared by the Income Maintenance Administration (IMA). He provided the team with a MMIS report titled "Recipient ACEDS Update Error Report." This report is generated daily by the contractor and notifies MAA if there is a problem with a particular recipient file. It provides data such as the case number, recipient identification, recipients name, error message, and action taken.

Original Finding:

27. **MMIS does not always attach an edit code to the names of physicians whose licenses have expired.**

Current Status: In Compliance.

During the initial inspection, the team noted that a physician's license to practice medicine in the District must be renewed every 2 years. Unfortunately, MMIS did not always attach an edit code to the physician's name when his or her license expired. Consequently, an unlicensed physician might continue to provide services and be improperly paid.

According to the Chief, issues relating to expired physicians licenses and edit codes were abated with the implementation of the new MMIS. The current system has the physician's licenses expiration date entered on the file. Upon expiration, MMIS automatically attaches an edit code canceling the physician's eligibility and stopping reimbursement of claims for any services provided after that date. Once MAA receives a renewal notice from a physician, MAA generates a memorandum to the contractor authorizing reinstatement.

The Deputy Chief of Program Operations provided an ad hoc report from the contractor dated March 5, 2003, that showed 5,258 providers in MMIS, of which 539 were ineligible due to expired licenses.

Findings and Recommendations:

MEDICAL PERSONNEL, PHARMACY UNIT

Original Finding:

28. **Certain MAA staff members working in Program Operations could work more efficiently if assigned to the Office of Quality Management under the direction of the Medical Director/MAA.**

Current Status: In Compliance.

The Physician's Assistant and the head of the Office of Quality Assurance are both now located at 825 North Capitol Street with the Medical Director. The Office of Quality Assurance oversees the viability and effectiveness of medical programs and clinical services, so its function is closely intertwined with that of the Medical Director. Since the relocation, communication and collaboration are much easier. The pharmacist and two other Health Systems Specialists are still located at 2100 Martin Luther King Ave, SE. However, the Medical Director does not need to collaborate with them often, so this does not impede MAA operations.

Original Finding:

29. **The HSS and the pharmacist are doing jobs that should be done by a staffed unit.**

Current Status: Partially in Compliance.

Not in compliance. The Health Systems Specialist (HSS), who is a Physician's Assistant, still has many responsibilities, including handling pending claims for individual consideration, reviewing pending claims that need pricing, preparing yearly code updates, preparing and reviewing paperwork for organ transplants, reviewing special medical-requests, reviewing undocumented alien claims, authorizing out-of-state-services, and other duties. The Physician's Assistant stated that because she has so many responsibilities, it is difficult to complete all jobs thoroughly and expeditiously, and she has no time for routine administrative duties. Currently, the MAA pharmacist is acting as the head of the Office of Quality Assurance, which requires that she perform many other responsibilities.

Although the unit has had several temporary administrative assistants since the initial inspection, they have not permanently alleviated the problem. However, to help ease their administrative burden, employees have stated that they have created several internal mechanisms to ensure that administrative work gets done more efficiently.

In compliance. Previously, when the Physician's Assistant was absent, her tasks went undone because no one else knew how to perform them. Currently, the Physician's Assistant and the Nurse Consultant in the Office of Quality Assurance are now cross-trained to perform all major functions.

MEDICAL PERSONNEL, PHARMACY UNIT

Original Finding:

30. There are no procedural manuals for the tasks performed by the HSS.

Current Status: In Compliance.

The HSS has written policies and procedures for all major tasks that she performs. The written policies and procedures are used as an official reference.

APPENDIX

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

DIRECTORATE OPERATIONS

1. **Neither MAA nor any other appropriate District agency has taken action to recover millions of dollars in erroneous Medicaid payments first identified in a January 15, 1997 audit by the Office of the Inspector General.**

That D/MAA coordinate with the appropriate District and federal government entities to recoup the erroneous Medicaid payments made from 1993-1996.

Current Status: In Compliance.

2. **Systems Management Branch employees bypass Automated Client Eligibility Determination System (ACEDS) supervisors when requesting database changes and reports. As a result, ACEDS supervisors are often unaware of changes that have been made to the ACEDS/MMIS interface.**

That D/MAA ensure that members of the MAA Systems Management Branch coordinate with ACEDS supervisors to determine how change and report requests should be handled.

Current Status: Agency disagreed with this Finding.

3. **MAA is not in compliance with federal regulations regarding training and employing sub-professionals and volunteers.**

- a. That D/MAA ensure that managers become familiar with the State Plan requirements and take necessary steps to establish a program that will fulfill the requirements for training, the use of sub-professionals and volunteers.

- b. That D/MAA explore the use of interns from the public health programs of local colleges to fulfill the volunteer requirement.

Current Status: Partially in Compliance.

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

4. **The SUR Unit lacks sufficient staff to effectively perform utilization review of the Medicaid program for possible fraud and abuse.**

That the SUR Unit be staffed with sufficient personnel to fulfill its mission. Emphasis should be placed on staffing the unit with an appropriate number of both analytical and health care professionals. The SUR Unit supervisor stated that at least eight more people are required in order to carry out the unit's mission effectively.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

Current Status: Status: Not in Compliance.

5. **SUR has no written policies governing the terms and conditions of repayments by providers when they have been overpaid.**

That D/MAA direct the creation and promulgation of written policies and procedures for a provider repayment process and a collection and tracking process to ensure provider compliance with repayment schedules. All employees affected should be given the appropriate training.

Current Status: Not in Compliance.

6. **The Surveillance and Utilization Review (SUR) Unit has recouped and/or identified for recoupment a substantial amount of Medicaid funds in FY 99 and FY 00 despite its staffing shortage.**

No recommendation made in the original Report.

7. **The Surveillance and Utilization Review Subsystem (SURS) of the MMIS is outdated and inefficient compared to systems being used by other States.**

That D/MAA and all appropriate managers and supervisors ensure that the appropriate technology and systems requirements are included in the contract for the enhanced version of the proposed MMIS now being solicited for the District.

Current Status: In Compliance.

8. **Parameters for the MMIS SURS have not been updated and the SUR staff is not trained on how to change them.**

That D/MAA ensure that the contractor provides proper training to the SUR Unit staff as soon as possible so that they can change the parameters on the current and future SURS subsystem.

Current Status: In Compliance.

9. **The MMIS contractor has not provided sufficient training to enable SUR employees to develop requests for required reports.**

That D/MAA ensure that the contractor provides SUR Unit personnel with the necessary training on the SURS to increase their ability to effectively perform their tasks. The training should cover all capabilities of both the current and future systems.

Current Status: Not in Compliance.

10. **Some SUR personnel are not adequately trained to detect provider fraud and abuse**

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

or how to conduct provider audits.

- a. That D/MAA direct SUR supervisors to establish a formalized training plan as soon as possible that will ensure that SUR employees receive the necessary health care fraud, audit and related training.
- b. That SUR Unit supervisors coordinate with the District MFCU on what additional training they may be able to provide or recommend to the unit.

Current Status: Not in Compliance.

11. The SUR Unit lacks the equipment necessary to effectively conduct audits.

That D/MAA ensure that the SUR Unit receives the necessary data processing equipment, cellular phones, and vehicles it needs to conduct effective and timely audits.

Current Status: Not in Compliance.

12. The SUR Unit has no written policies and procedures governing how the unit conducts its daily operations.

That D/MAA ensure that the SUR Unit supervisor creates, promulgates and updates written policies and procedures for all significant day-to-day SUR operations.

Current Status: Not in Compliance.

13. SUR Unit supervisors have not developed written performance standards for unit personnel.

- a. That the SUR supervisor establish clear, measurable standards for each critical job element for all employees.
- b. That the SUR supervisor counsel employees periodically on performance standards and what constitutes satisfactory performance.

Current Status: Partially in Compliance.

THIRD PARTY LIABILITY SECTION

14. Resources for the operation of third party recovery efforts are limited. Overall revenue recoveries are not maximized.

That D/MAA establish a 30-day task force to determine the best course of action for the TPL operation. Plans to strengthen the in-house operation should be subjected to a cost benefit analysis, and immediate improvements such as online service connection with MMIS are needed if the in-house operation is to be strengthened. MAA should review its use of a third-party collection contractor for those operations that may or may not be cost effective if done in-house.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

Current Status: Not in Compliance.

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15. MAA employees cannot account for many claims that are pending payment that have been sent to MAA for review.

- a. That D/MAA direct the Chief of Program Operations to immediately locate and report back on all pending claims.
- b. That an in-house database be developed to track all claims sent to MAA for review. The database should include a means to identify claims with a pending status that have exceeded a timely review period.
- c. That the Chief of Program Operations designate staff members to be responsible for follow-up on all pending claims sent to MAA.

Current Status: In Compliance.

16. Monitoring of out-of-state claims that have been placed in pending payment status due to a lack of rate information is insufficient and irregular.

- a. That D/MAA ensure that the Program Operations office establish a tracking method to identify out-of-state claims where rate requests have been sent, but not responded to within a certain amount of time (i.e. 60 – 90 days).
- b. That D/MAA ensure that the Program Operations office establish a procedure whereby rate requests for these claims will be resent to the out-of-state Medicaid Office when there is not a timely response.
- c. That D/MAA ensure that the Program Operations office establish as a priority the clearance of all claims that have been pending for two years or more for out-of-state rate information. For out-of-state claims where rate information is no longer available, a policy should be established as to how, and at what rate these claims are to be paid.

Current Status: In Compliance.

17. There is confusion within Program Operations regarding the processing of \$2.6 million in billed claims from out-of-state providers.

- a. That D/MAA direct that the backlog of pending claims be processed as soon as possible.
- b. That D/MAA direct the Chief, Program Operations to establish a comprehensive procedure for processing out-of-state claims.

Current Status: In Compliance.

18. Claims that are in a pending payment status are being re-submitted by providers for processing in violation of the Medicaid State Plan regulation.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

That D/MAA direct the contractor develop a program within MMIS that will automatically deny pending claims that are resubmitted for processing prior to being denied.

Current Status: In Compliance.

19. **The Program Operations staff is accepting providers' personal checks instead of the required Adjustment/Void forms for refunds of money owed to Medicaid for duplicate claims or overpayment of claims.**

That D/MAA direct the Chief of Program Operations to establish a system to account for refunds by providers who do not use the correct form.

Current Status: In Compliance.

20. **Some providers send unnecessary medical records along with claims. These records often contain confidential patient information that is thrown into the trash without being shredded.**

- a. That D/MAA direct the contractor to send out notices to all providers instructing them not to send in recipient medical records, and to provide them with a checklist of the appropriate paperwork needed to accompany claims.
- b. That D/MAA require the contractor to shred all documents that are not required to process a claim.

Current Status: In Compliance.

21. **MAA pays claims for residual amounts billed to Medicaid without knowing the requisite medical procedure codes or amounts already paid by Medicare. This could result in payments being made that exceed the allowable amount.**

That D/MAA request a format change within MMIS for crossover payments requiring input of payments already made and procedure codes. Edits in the system should check the payments made against the Medicaid threshold payment for each procedure. When payments made already exceed the Medicaid threshold, claims submitted for residual amounts should be denied.

Current Status: In Compliance.

22. **Adjustments or additions to pricing are not documented as required by the Code of Federal Regulations.**

- a. That D/MAA comply with Title 42, CFR Section 447 by establishing procedures outlining percentage amounts, policies and procedures for setting procedure rates, and by keeping a log for all additions and/or changes.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

- b. That MMIS be formatted to automatically calculate rates for Medicaid services using the Medicare rate or the provider's customary charges on procedures not already priced.

Current Status: In Compliance.

23. There is no system to verify that recipients have received services billed to Medicaid.

- a. That D/MAA mandate that a percentage of recipients be contacted monthly by telephone to verify services billed.
- b. That D/MAA develop and implement a District-wide public education program that asks citizens to report provider fraud and abuse.

Current Status: In Compliance.

24. The telephone system in Program Operations makes it difficult to contact a live person.

- a. That D/MAA ensure that the telephone system for the Program Operations office be reconfigured to roll all telephone calls from the old number for Program Operations over to the newly established main number.
- b. That D/MAA ensure that the new telephone numbers for the MAA staff be supplied to the Mayor's citywide call center so that persons seeking telephone numbers can be given the correct number.
- c. That D/MAA ensure that someone in the Program Operations office and a backup be assigned to routinely listen to, take messages, and respond to messages left on the voice mailbox. A receptionist or staff person should be available at the main number during work hours to transfer calls so that fewer calls will go to the voice mailbox.

Current Status: In Compliance.

25. Telephone calls received by members of the Program Operations staff from recipients and providers are not logged or tracked.

- a. That D/MAA ensure that the Program Operations staff document all calls received and their disposition on a caller log form that should be simple and easy to complete, yet provide enough information to be useful in disputes.
- b. That the Chief of Program Operations require that all requests for claims information from providers and recipients that may be subject to dispute be put in writing.

Current Status: In Compliance.

26. System errors in the MMIS have caused incorrect cross-referencing of recipient files.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATION

That D/MAA direct the contractor to implement a systemic fix to the cross-referencing problem as soon as possible. A deadline for correcting this problem should be established and adhered to.

Current Status: In Compliance.

27. MMIS does not always attach an edit code to the names of physicians whose licenses have expired.

- a. That D/MAA require the contractor to correct the program in MMIS so that errors in physician license edits are corrected.
- b. That D/MAA require the Chief of Program Operations to develop a separate in-house database to track physician license expirations.

Current Status: In Compliance.

MEDICAL PERSONNEL, PHARMACY UNIT

28. Certain MAA staff members working in Program Operations could work more efficiently if assigned to the Office of Quality Management under the direction of the Medical Director/MAA.

That the HSS, the Pharmacy Unit, and all other medical personnel be placed under the Medical Director/MAA and co-located in the same building.

Current Status: In Compliance.

29. The HSS and the pharmacist are doing jobs that should be done by a staffed unit.

- a. That the HSS and the Pharmacy Unit be provided with an appropriate number of support employees.
- b. That someone be trained as a backup to the HSS in her absence.

Current Status: Partially in Compliance.

30. There are no procedural manuals for the tasks performed by the HSS.

That the Chief of Program Operations assign a staff member to coordinate with the HSS in preparing procedural manuals covering all of her job responsibilities.

Current Status: In Compliance.